Overview

1. Clarifying the Purpose of this Stage of the Project

Based on some of the comments received at the kick-off meeting on March 14, 2012, as well as in writing, it is helpful to clarify the purpose of this stage of the project.

During 2011, Deputy Secretary Renata Henry retained a consultant to evaluate the provision of behavioral health services. In her final report, the consultant noted that Maryland's system has many strengths. The consultant also noted, however, that the lack of alignment between mental health services and substance use disorder services was an area where Maryland could improve. The consultant recommended that Maryland pursue a plan to align services.

This project builds on that report. As directed by Secretary Sharfstein, by September 30, 2012, the Deputy Secretary for Health Care Financing should make a recommendation on the best model to better align behavioral health services, and to align with somatic health. The next few months will solicit broad public input to inform this recommendation.

The ***next*** stage of this overall project will be to execute the plan to accomplish that recommendation (as it may be informed by potential legislation in the 2013 legislative session). In the next phase, the Department will need to work with stakeholders on elements that might be necessary to implement whatever model is pursued. These elements may include: a federal Medicaid waiver(s); one or more RFPs; contractual standards governing issues like credentialing, performance measures, reporting, value-based purchasing incentives and sanctions, advisory groups, etc.

In short, the goal of the current stage of the project is not to develop the detailed specifications of any contract, waiver, or measure. That will come later. Rather, this stage of the project involves evaluating the potential high-level models, in order to make a recommendation by September 30, 2012.

2. Clarifying the Scope of Programs under Consideration

Additional clarification is also warranted regarding the scope of programs that would be incorporated in the model. Please note: the behavioral health integration work that is the focus of this project involves **Medicaid-financed** services. The goal of this work is to align Medicaid-financing on a timeline that is coextensive with the Medicaid expansion (and other coverage expansions) that are effective on January 1, 2014.

This project will **not** be premised on a goal of integrating other state-only funded programs (administered directly at DHMH or at local agencies through grants from DHMH) directly into this model.

One of the workgroups specifically was established to consider (and, where appropriate) make recommendations on how other state-only funded programs could "wrap around" the Medicaid-financed integrated services that are the subject of this project.

3. Revisions to Documents, based on Stakeholder Feedback

A number of revisions were made to the documents based on stakeholder input.

Criteria. Additional criteria were added, and more clarity was provided to define certain criteria.

Models. The second model was revised to reflect stakeholder input. In particular, commenters suggested that more than one behavioral health organization could potentially be selected and a model that involved significant performance risk could be considered. The other two models received no comments.

No additional or alternative models were suggested by any commenter. As a result, we will limit our consideration to the three models that were presented (as revised).

Workgroups. A number of changes were made. First, two earlier workgroups were consolidated: the state/local workgroup, and the non-Medicaid workgroup. In general, commenters indicated that the scope of these two workgroups is so overlapping that the issues should be considered together.

Other workgroups were suggested. In particular:

First, a number of people suggested various "population specific" workgroups, to address children, seniors, or other populations such as people leaving the criminal justice system. We elected not to reflect any "population specific" workgroup, which seemed to violate the criterion of developing a model that would meet the needs of a person over the course of his/her lifespan. However, because of the Medicaid-specific issues of EPSDT, we think that all workgroups should consider whether any special provisions should be made with respect to children.

Second, a number of people suggested a workgroup on "workforce", sometimes recommending that a workgroup focus on capacity-building (expanding the workforce), and sometimes recommending that a workgroup address the inconsistency that sometimes exists between the Department's standards and rules in mental health and substance use, respectively. With respect to capacity-building, the Governor's Office of Health Care Reform is working hard on this issue, across all disciplines (including behavioral health). With respect to aligning the Department's rules, those efforts are underway in a parallel project that is occurring outside this model-development effort.

4. Summary of Other Comments Received

We would like to thank everyone who submitted comments. We received a wide variety of comments beyond the ones mentioned above. Most comments have been incorporated into the final workgroups, potential models, and criteria for evaluating the potential models. Some of the comments were not incorporated into the final documents, and we will explain our rationale for not including them below.

Some comments were not incorporated because they did not speak directly to the charge of this project. For example, we received some comments that spoke to clinical issues at the clinical setting level, or details that should be included in RFP if one or more procurements are pursued. While all of these issues are extremely important, developing those details will be the focus of the next stage of this overall work, after a model is chosen, and needs to be implemented.

As mentioned above, we received many comments suggesting the creation of a workforce workgroup. We recognize that workforce issues are critical to any model that is selected. However, we felt that the workforce issues do not drive the selection of the model; rather, that any model selected will have to develop mechanisms to promote workforce development and align training, credentialing, assessment, and other elements. Further, work is already taking place around the State on this issue and we did not want to duplicate efforts. For instance, the Governor's Office of Health Care Reform is convening a group to discuss workforce issues across all disciplines.

Also, as mentioned above, comments were received suggesting workgroups that focused on the needs of specific populations. We believe that dedicating a workgroup to any one population would beg the question of why that particular population was selected and not other populations. In addition, we would not want to erode the criteria of "care across an individual's lifespan" by segmenting populations based on a static characteristic such as a particular age.

A few commenters expressed reservations about a model that is evaluated on performance and outcomes. One commenter, for example, indicated that some conditions are degenerative, and therefore focusing on outcomes might not be appropriate. We respectfully disagree. Whatever condition may exist, better outcomes may be pursued, such as care that better maintains functioning, or avoids admissions, or improves satisfaction. Put another way, we recognize that not all conditions are premised on a recovery model (e.g., Alzheimer's disease), but nevertheless outcome measures are appropriate.

Thank you again for your insightful comments. If you have any questions, please don't hesitate to write to us at bhintegration@dhmh.state.md.us.